HIEPI Business & Technical Operations Workgroup Meeting

Meeting Owners	Bill Baggeroer (WG Lead) Tim Andrews (WG Facilitator)
Minutes Authors	Diana Quaynor (WG Business Analyst)
Version	1

Date	7/26/10
Time	9 a.m. – 1 p.m. / ET
Location	(877) 449-6558

AGENDA

Topic "Converging on solutions"	Led By	Start	End
OPENING REMARKS, purpose of summit 3 (final planning summit)	Bill/Tim	9:00 AM	9:15 AM
Review & identify approach & gaps: • Review the unified approach emerging from the various WGs • Identify gaps and concerns with strawman phasing • Identify cross-domain gaps or dependencies not addressed in unified approach.	Tim	9:15 AM	12:45 PM
WRAP UP & next steps	Tim/Bill	12:45 PM	1:00 PM

ATTENDEES

Name	In Attendance (Y or N)	Name	In Attendance (Y or N)
Bill Baggeroer (NH Lead)	Y	Mary Brunette, MD	N
Carol Roosa	Y	Mary Hunt, PA-C, MHS	N
David Briden	N	Patricia Witthaus	N
Diana Quaynor (BA)	Y	Peter Malloy	Y
Doris Lotz	Y	Sandy Pardus	Y
Fred Kelsey	Y	Scott Maclean	N
Heidi Johnson	Y	Shawn Tester	Y
Hillary St Pierre	N	Theresa Pare-Curtis	N
Janet Horne	Y	Tim Andrews (Facilitator)	Y
Kerri Coons	N	Trinidad Tellez	N
Lorraine Nichols	N	Wendy Angelo, MD	Y
Marcella Bobinsky	Y		
Mary Beth Eldredge	Y		

GUESTS

Name	In Attendance (Y or N)
Mark Belanger (PM)	Y
Micky Tripathi (Program Lead)	Y

* Via telephone

MEETING HANDOUTS

1. <<HIEPI Business and Technical Operations 26- July- 10.pdf>>

MEETING SUMMARY

1. Opening remarks – leader thanks WG members for their input and getting us where we are today. A draft SOP will be ready in about a week for review. Today we will be reviewing and identifying our approach & gaps. The goal is to reach some sort of consensus & discuss what makes us comfortable and uncomfortable. For the members who did not already know Micky (CEO of MAeHC and program lead for the project) introductions were made. Micky at present has the broadest view of the cross WG decisions.
2. Review the unified approach emerging from the various WGs.
    a. Slide 4 – PIN notice focuses on lab results, e-prescribing, care summary.
        i. There are some things that we don't have in great detail & therefore identifying gaps can be difficult. Micky will talk later about the informal data with the CIOs.
        ii. Ideally, we will have data & can do gap analysis.
        iii. We could look at facilitating capabilities and there is lots of flexibility in doing that. What's the best we can do to put in place use cases, at a minimum?
    b. There are 3 things we can do:
        i. We can establish infrastructure.
        ii. We can just do governance through leadership & other mechanisms
        iii. We can turn down funds

        ONC's goal is not to control what states can do, but wish to catalyze the process. The big challenge is having the consensus process and making decisions in short a short period of time.

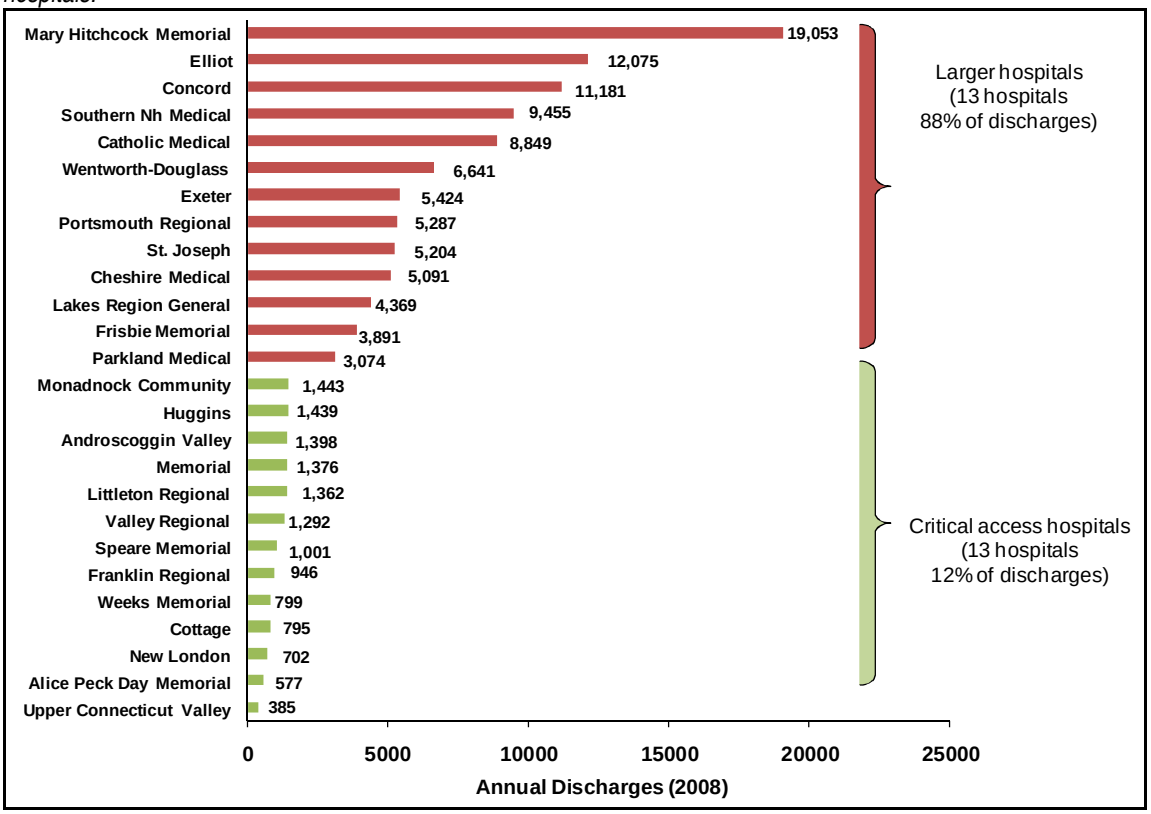
        Q: What is care summary exchange??
        A: It is the exchange of key clinical information. Technically, they talk about CCD/CCRs, discharge of admission to the hospital. It is documentation that accompanies transition of care, but it also covers sending something to a patient (e.g. to a PHR)
        Q: It used to say eprescribing (eRx), lab results & immunization – did immunization go away?
        A: PIN's emphasis was not on immunization, but they did discuss public health. MU & PIN aren't quite synced up. MU made a significant change with lab results, & summary of care, but public health is in the optional set.
        Q: Summary of care --is it push technology?
        A: All transactions for stage 1 are push, i.e. you must be able to "push" summary of care to patents electronically. There are several optional electronic methods and one required – paper. Paper is an electronic option. You must provide paper copy if requested.
        Comment: one surprise in the Final Rule is definition of ED. Push is a challenge and is thinking of how we'll write that.
        Response: if you didn't include ED, you lost a lot of discharges, even eprescribing. The push to include EDs was to get over the statistical bars, but they changed the rule of all orders.
        Comment: Yes, this made things worse for their organization because they don't force their ED docs to do electronic or use CPOE.
        Response: when they thought hospital, they primarily thought inpatient, but after the first round, there was a recommendation that hospitals do a lot more.
        Q: Question about review & approval process--what is the process? Can ONC just say no, thanks-- nice try?
        A: There is a project officer for each state—for NH, it's Molly Smith. She accepts your plan & along with a technical cohort they evaluate our response. They can come back & say they don't like. They've given clear guidance, but they are well aware of how unreasonable the request is & will be as flexible as they can. ONC has been very good about having the discussion about what we need to do to have our plan approved. They can't reject—it's a cooperative agreement, but they can say it's not good enough. They want to see progress. This is stimulus fund & ONC is motivated to get the money spent. They want to see that you have a multi-stakeholder process and that you have established a robust process for moving forward.

        This is the background work we've done so far. NH has a very high penetration rate compared to most states, especially without a RHIO.

    c. Summary of Environmental Scan results received to date
        Within the hospital networks, the vast majority of exchange is occurring between hospitals and their employed ambulatory physician practices

i. Since well over 50% of ambulatory physicians are employed by hospitals, this represents relatively high penetration of health exchange capabilities (with the assumption that if you are part of a hospital network, you are more likely to be using an EHR)
ii. Hospitals have also established health exchange capabilities with affiliated ambulatory physicians, though with lower penetration and for fewer types of transactions

Comment: Bill was asking where we stood on the survey.
Response: We have about 50% response so far. Mary-Beth is helping with that and Kathy Bizarro. In general it looks like the % employed (employed + affiliated) of the 12 processed brings the number up to about 65%. Therefore, the gap is more like 35%. EHR penetration was about 46%. We have surveys from the following hospitals:



Comment: if there are some surveys that Micky can't get, please get in touch with WG members and as they can get involved to help get the needed information.
Comment: survey was more involved so some may have put it away to get more information for it later. Plus there was some confusion with the number of surveys received.
Comment: The UNH survey is covering Medicaid. Patrick Miller is sending out a broader survey that provides a different perspective and asks practice level questions.

d. Survey GAPS
i. There was a whole set of questions on the use cases. Claims & eligiblility checking was something most people did, but as you go down the list of questions, you see more variation, e.g. an interface for lab results—2 through portal, 2 through interface, then a broad response from fax to multiple methods. For both hospital & affiliated physician, number needs to be increased for MU.
ii. Share svcs – which of these would you want to purchase for a statewide HIE – 2 hospitals said they were not interested in any, but of the remainder – 6 replied yes, 2 replied maybe on MPI on shared basis. NIEHIN – 8 out of 12 responded yes. RLS--##? Performance testing – 3 out of 12. There's more data to come, but that's what they are finding so far.
iii. There survey results match less than what we thought walking through the door. The numbers look more like 65% instead of the 85% we were told about at the beginning of the project.

Comment: there are major hospitals not included in that (especially 3 major ones).

Response: True, but we'll have to make caveated judgment about where we are.

iv. The gaps that we truly care about are:
    1. Employed and affiliated physicians within hospital service areas who do not yet receive MU-level transactions through their hospital network.
    2. Ambulatory physicians outside of existing hospital networks for whom no plan exists today for health information exchange.
    3. Hospital-to-hospital exchange, which is mostly non-existent except for a very small number of bilateral exchanges between hospitals.
    4. Cross-state health exchange for all hospitals and physicians, for which no electronic exchange capabilities exist today.

    Q: One of the major gaps is that there are major providers who don't have EHR. Is there a requirement to state how we're going get them one?
    A: Not in this plan. That's a primary responsibility of the RECs. We have to make it easier to help the provider get MU payments. One of the things in the PIN that we have to address in terms of data collection is what pharmacies are connected, how many eprescribing transactions are happening to get a longitudinal trend line across the services.

v. Legal & Policy Environment
    1. Transactions through an HIE entity are only allowed for information sharing among providers for treatment purposes
        a. Excluded transactions include reporting for public health, performance/measurement, MU-reporting to Medicaid & Medicare – big constraint on us, but it just means we can't do it today. We don't want anything in the plan that isn't legal. We can say we want to do this if & when it becomes legal (rather than say we are going to do this and will see to it that it is made legal)
    2. Also requires patient opt-out for any transactions conducted by the HIE entity, and audit of all transactions including sender, receiver, and identification of patient. Legal & Policy WG received clarity that we can do transaction of PHI, but can't peak inside, but once you do peak inside then auditing & consent come to it.

        Q: What are the operations & technical requirements for the opt-out?
        A: Secure messaging push technology. The technical Infrastructure group has done some work on what it takes. The problem with this law is that it's really broad. If there's no PHI in the HIE it's OK, but PHI in the HIE raises the business & technical operations level.
        Q: Is the intent of the law to have solely opt-in & opt-out or will there be variations? Who's on top of this?
        A: Legal & Policy as well as Governance are primarily addressing this. We figured that there was no way we could get through this by end of August. We thought it best to get through phase one. Then there will be a governance process in place and they can start to address some of these issues.
        Leader Comment: Information in plan has an emphasis or specificity for phase 1, but we raise questions about what we need to do & describe how to address the main issues (without actually addressing it).
        Response: ONC is fine with us stating what the issues are and us saying the timeline in which we will address it.

vi. Public health reporting is statutorily required; however, the current law does not allow such transactions to be brokered by an HIE entity.
    1. There are currently a wide variety of public health reporting requirements and systems.
    2. Forces ad hoc point-to-point electronic and non-electronic solutions between providers and DPH.

    Response: all providers can send data to PH individually, but not through an HIE.
    Comment: GE had a contract with CDC for flu data, so the state is already doing that.
    Q: Is the state able to accept point-to-point from the providers?

A: Yes, there are electronic point-to-point transactions with Public Health Today. The Public Health WG is defining how an HIE could replace today's point-to-point connections..
Q: Is there CDC money to get some sort of electronic exchange?
A: Yes, the state is trying to align that effort better.

vii. Finance
   1. There is currently no State general funds available for HIE activities, and no expectation that such funds might become available in the near future
      a. Potential for State in kind match to cover first year match requirement (~$200K)
      b. Good news: Medical had received news that matching funds can be designated from the exact enactment of the law, which is much longer than most anticipated.

viii. Use cases – we were quite successful in working through them and divided them up in 3 phases:
   1. Basic secure routing
   2. Extended secure routing
   3. Community record structure with pull

ix. (Slide 9) – there is a brief summary of what the other WGs did
   1. Limited funding constraints & legal constraints.
   2. Came to agree on hub of hubs model.

Comment: Please don't convey that all the large systems don't find value in phase one. At least one does.
Comment: there are technical hurdles (MPI), but there's value otherwise. See it more as a technical infrastructure issue.
Comment: It needs to be clear that secure messaging of structured data messaging is included. Most people do textual already (e.g. PDF or HL7 of mostly text).
Response: if you get HL7 v. 2.5.1 can you parse it?
Comment/response: WG member did not know.
Response: This is all a gross oversimplification, but it's a good point to be more specific/less abstract.
Comment: for the small person in the small shop, structured data is of high value; if data can drop into flow sheets. Preloading is huge. Recommendation: change slide to say it's "of relative HUGE apparent value" instead of limited.
Q: Being able to identify & retrieve "records" –are we talking about structured or unstructured data?
A: Yes, we were always thinking of structured. CCDs/CCRs accept textual documents.
Response: Hopefully, since MU has a clear requirement for structured data, the vendors will have to work towards that; not just the receivers. We need to be as incremental as we need to be to make it work.

x. Governance – there's clear desire for public instrumentality. Right now the state has to pull the contract and be the fiscal entity.

Comment: NH Healthy Kids is the model (ability to connect to the state, but with autonomy). It's been a very positive, well structured model. What's the transition governance structure? How do the WGs continue through phase 2 & 3 and then retraining new people.
Response: the push is done through phase 1, we want to establish governance for phase 2. New workgroups will not be much different in composition. That is usually the easy part; the hard part is participation because of FT jobs, etc. State has regulatory & statutory involvement, but stakeholder involvement is of paramount importance.
Q: Are there any learning points from Healthy Kids?
Comment: It has been difficult at times, but Governance is looking at the high level infrastructure to try to align with the state & allow private funds.
Comment: it is important to put value to an entity that will tell stakeholders how to collaborate, rather than just anticipating that these organizations can get along just fine.
Comment: In terms of using Healthy Kids as a model, don't just think about where you are now, but also think about where it might change. Bring stakeholders that you may need much further down the line? (e.g. dynamic changes in SCHIP are encumbered by Healthy Kids.)
Finance WG: has started with what they know- that they have the federal funds

Q: 200K matching- is that a requirement that it come from the state or someone else?
A: Someone else. There are no requirements that the matching funds come from the state general funds
Comment: insight into state politics – providers will come into process & say why did you do this? But along the way that voice will be lost as you move through the process.
Response: state is very important in all of this—Medicaid. They are well funded.
Leader response: Finance team & others also looking at others to find additional funding.

That's where we got to with the current WGs.

(Slide 10) From all the work we did with use cases and understanding the environment from the other WG's input, we were able to prioritize, not just because of legality, but also from difficulty.

- Phase 1 – Can be launched with federal HIE program funds
- Phase 2 – No market alternatives, but law needs to change
- Phase 3 – Even more technical & legal difficulties to overcome

(Slide 11, 12 & 13) Phasing

- Phase 1 mostly driven by MU requirements.
- Phase 2 requires a lot of workflow change, low demand or restricted by law and has technical & organizational complexity & technical requirements of other care settings are unknown.
- Phase 3 (e.g. radiation exposure report has a lot of issues to sort through & may be illegal). We don't want to replicate existing capability & there is a high demand.

(Slide 14) Well aligned with NHHA consensus priorities.

(Slide 15) We have:

- Law
- Limited funding
- No organizational capabilities (we need mechanisms to maintain EMPIs, for example)
- Program requirements focused on eRx & labs & summary exchange.

(Slide 16) This was the earlier graphic of the backbone & what's in the backbone. What would be a way of aggregating the orphans? Question is whether we can scrub all this to fit into phase 1. Then Governance allows transition to private investors.

Comments: NY has a committee that takes in the funding.
Response: NY has an SDE (state designated entity).
It could be as quickly as June or July 2011 when the governing entity can be formed & taking any kind of responsibility.
Comment: What is the role of David Towne & the new PM (Elizabeth Shields) specifically related to the HIE function. What role do they play in communication?
Leader comment: communication strategy- Bill is forming Communication WG to spread the word. Dave and Elizabeth are part of that WG.
Comment: There was a suggestion to have a public information session to get more in the public. WG member is ambivalent to doing this because of the technical details and understanding needed on this material. It could open up a can of worms.
Comment: community mental will eventually be on the train, but it's good to have their IT folks informed now about it.
Response: 40 stakeholder groups with 83 stakeholder representatives will have been involved in this process. The Communication WG will have to craft appropriate messages for different audiences.

3. (Slide 16) Our consensus therefore is:
    a. Build a technical platform that provides core functionality and is extensible for future functions
    b. Build an organization platform to sustain secure routing services and demonstrate ability to collaboratively scope, manage, and execute jointly funded HIE projects

c. Build a multi-stakeholder governance process to refine Phase 2 and 3 projects, shape statewide policy related to health information exchange, and identify funding approaches for future statewide activities
d. (Slide 17) Finance is still in the cast the net widely mode. They roughly estimate $1M dollars that have to be matched. They are also looking at various options for the ongoing work:
    i. Mandatory vs. state-directed mandatory.
    ii. Types of assessments (whether on premiums, on hospitals, on physicians, etc.)
    iii. Not required by the state.
    iv. Goal is to have a business plan within a year.

Comment: "Statutorily required public health reporting" – is that defined? Micky said that he would remove the word "statutorily" from the slide.
Comment: Going forward it will be very important to keep these same teams or some semblance of these teams involved in the process going forward because a change in the groups can change or reverse our decisions.
Comment: This is a very good slide to show where we are.
Comment: There is subtlety in Finance detail about identifying opportunities leveraging Medicaid, public health & Medicaid funding. The 2 Medicaid items are different.
Comment: Integration of Medicaid needs to be aligned so the WG & Medicaid are both going in the same direction.
Response: There is real pressure from ONC to make sure it's a real integration.
Comment: is it fair to say that the ONC plan may have more detail than the high-level review the WGs have gone through in the last couple of weeks.
Response: Yes, this is a starting point; it's a general outline and everyone should be prepared to read fully the plan for more in-depth descriptions of plan.
Response: What's important is that where we can decide we should decide. Where we need further work, we need to articulate that, establish a process for addressing the issue and say how long we think it will take.
Comment: Consent & opt-out—if that's the framework we have to operate in, how do we do it?
Comment: strategy of identifying issue and talking about some possible solutions—a little extra level of drill-down is what we need to do.
Comment: There are next steps beyond the plan that we need to be thinking about.
Response: This is the governance transition we're talking about to continue addressing issues that were identified.
Response: It has to be phased.
Comment: In terms of the technical infrastructure, the WG has to be thinking about phase 2 & 3 to make sure the phase 1.

4. Closing remarks: Process for finalization of plan
    a. MAeHC will have draft plan finalized for end of Aug 6th.
    b. Needs to be turned around very quickly by Aug. 12th.
    c. We will get comments integrated & addressed.
    d. There will be a second draft on or around Aug. 22nd, which has to get to a steering committee.
    e. Final state approval happens on Aug. 31st.

Q: How do we get to a comment review process?
A: We could do F2F if we need, but we think a conference call for sure.
Comment: the WG leads felt it necessary to use the comment tracking spreadsheet.
Leader Comment: Dave Town, Mark Belanger & Elizabeth (name), PM to send out communication about the process for feedback.

    f. Diana will send out a Doodle later this week for a review session of the draft plan.

ACTION ITEMS (FROM PREVIOUS MEETINGS AND NEW)

Item #	Raised By	Action Item Description / Comment	Assigned To	Due Date	Status/ Remarks

Item #	Raised By	Action Item Description / Comment	Assigned To	Due Date	Status/ Remarks
1	Tim	Think about critical and valued use cases for New Hampshire in terms of where we want to prioritize our activities.	All	6/28/10	Ongoing until 7/6
2	Mary Beth	Suggested Collaborative Tools: GoToMeeting and WebEx for T-Cons.	Bill	7/6/10	Agreed GoToMeeting provided.
3	Diana	Clarify/define some key terms, e.g. ER vs. ED, Mental Health vs. Behavioral Health	All	7/6/10	
4	Tim	Need a parallel set of Public Health use cases from the state perspective	All?	7/6/10	Completed
5	WG member	A request to look into providing cc: on messages so that delivery can be to multiple providers.	Tim	7/12/10	Legal/policy decision
6	WG member	Look into Surescripts fill rate issue	Tim	7/12/10	Legal/policy decision
7	WG member	Determine whether we can include Home health care/VNA in routing - for discharge example	Tim	7/12/10	Legal/policy decision
8	Bill	Number use cases for ease of reference & name phases that each use case falls into	Tim/Diana	7/26	Completed
9	Diana	Doodle to set up a review call in mid August	Diana	7/30	

ISSUES IDENTIFIED

Issue #	Raised By	Issue Description	Assigned To	Due Date	Status/Remarks
1	Peter Malloy and others	Phase 1 does not present enough value-add without MPI for sustainable funding past phase 1. Tim & Bill will discuss with other WG leads.	Tim, Bill	7/26	Completed

DECISIONS MADE

Decision #	Sponsor	Decision Description	Approved (Y or N)	Comments
1		None		